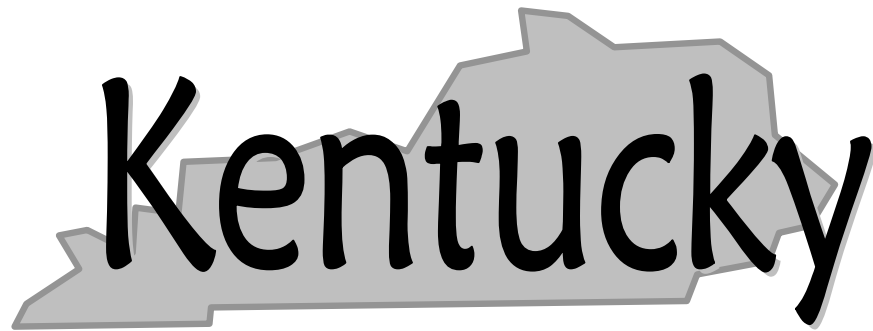


2010 ANNUAL SURVEY OF LICENSED HOSPITALS



January 1, 2010 - December 31, 2010

**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
275 EAST MAIN STREET 4 W-E
FRANKFORT, KY 40621**

Completion required by 902 KAR 20:008, (rev 10-15-03) and 900 KAR 6:125

2010 KENTUCKY ANNUAL SURVEY OF LICENSED HOSPITALS

PLEASE READ THIS PAGE CAREFULLY BEFORE BEGINNING

The Office of Health Policy in the Kentucky Cabinet for Health and Family Services is responsible for the development of the Kentucky Annual Hospital Utilization and Services Report. This survey is for the period **January 1, 2010 through December 31, 2010**.

The data requested in this document represent requirements approved by the Cabinet for Health Services pursuant to 902 KAR 20:008 (rev 10-15-2003) and 900 KAR 6:125. Surveys are due by March 15, 2011. Completion of this document is required in accordance with your Kentucky Hospital License. Failure to submit data timely and correct may result in the Office of the Inspector General being contacted regarding a licensure deficiency.

Please complete and submit the Hospital Utilization Survey on the following Internet Web Site: <https://apps.chfs.ky.gov/OHPSurvey/Default.aspx>.

Any changes in the services you provided from the last survey period should be footnoted. When a discrepancy in services is noticed between surveys, the cause must be determined. There will be space provided on the web site to explain any changes in service. Examples include: no longer providing a specific service, temporarily closing a service, commencing a new service, or reactivating a former service. Please provide dates for these changes.

Any survey found to have errors or omissions will not be considered received by the deadline and the Hospital Administrator will be contacted.

ADMINISTRATOR'S CONTROL CHECKS

The following data checks will be made by this office prior to acceptance of your data. Perform the same checks and make any necessary adjustments.

1.(a.) On page 3 subtract the total number of admissions from the total number of discharges. The difference should be less than or equal to the total number of beds in your facility. If the number is greater, an error has occurred and your data should be checked.

(b.)Next subtract the ending census December 31, 2009 from the opening census January 01, 2010. That number should also be less than or equal to the number of beds in your facility.

(c.)The results from each of the two subtractions done in steps 1 and 2 should be equal.

$$\text{December 31, 2009 Census} + \text{Admissions} - \text{Discharges} = \text{December 31, 2010 Census}$$

Example. Your hospital has 100 beds. The beginning census was 80. The ending census was 95.

Step 1. Admissions-discharges must = or be less than 100.

Step 2 Ending census (95) – beginning census (80) = 15

Step 3 Admissions – discharges must equal ending census – beginning census or 15.

2. Check for mathematical errors on page 5. All bed and inpatient day totals should be checked against their respective subtotals.

DEFINITIONS:

In all instances, unless otherwise specified, the terms used in this survey are the same as those found in the American Hospital Association AHA Hospital Statistics, 2005 Edition. Two specific areas require caution - surgical operations versus procedures, emergency room and outpatient visits versus services.

INSTRUCTIONS: Complete all items. If there are no data for an item, please use zero.

- Do not include births in the number of admissions or newborn days in the number of inpatient days. Include deaths in the number of discharges.
- Utilization data for chemical dependency, physical rehabilitation, or long-term care inpatients should not be included in this section unless beds licensed as acute care beds or psychiatric care beds were used to provide those services.
- Report all utilization of swing beds on line D. **However, CAH facilities should not enter swing beds on line D.**
- 23-hour or less observation patients should not be included in this section.

UTILIZATION DATA BY SPECIFIC SERVICE

Line C should express your facility's acute & psychiatric care operation only (Line A + Line B) including intensive care and Level II & III neonatal.

REPORT FOR THE PERIOD JANUARY 1, 2010 THROUGH DECEMBER 31, 2010

ACUTE AND PSYCHIATRIC UTILIZATION					
Service Unit	Beds in Operation (At end of reporting period)	Admissions (exclude births)	Number of Inpatient Days	Number of Discharges	Number of Discharge Days
Acute Care					
1. Med/Surg, Adult and Peds					
2. Obstetrics					
3. ICU/CCU/Burn					
4. Neonatal II/III					
A. Acute Care Total					
Psychiatric Care by Age					
1. Children (0 - 12 years)					
2. Adolescents (13 – 17 years)					
3. Adults (18-64 years)					
4. Adults (65 Years and older)					
B. Psychiatric Care Total					
C. Total Acute Care and Psychiatric Care					
D. Swing Beds					
E. LTACH					

Name of facility where LTACH beds are located: _____ Name of Certification holder for beds: _____

CENSUS AND LICENSURE DATA

If number of licensed beds changed between the First Day of the Reporting Period and the Last Day of the Reporting Period, please give date and type of change by category, e.g., 20 Acute Beds converted to 20 Psychiatric Care beds on 3-14-10.

CENSUS DATA

Acute and Psychiatric Care census as of Midnight, December 31, 2009: _____

December 31, 2010: _____

Number of 23-Hour **Observation Patients** January 1 through December 31, 2010: _____

How many of those patients were subsequently admitted: _____

Beds and Utilization by Licensure Category:

Licensure Category		Number of Licensed Beds Jan 1, 2011 (per Licensing & Regulation)	Number of Licensed Beds Jan 31, 2010	Number of Licensed Beds Dec 31, 2010
i.	Acute Care (please read * below)		_____	_____
ii.	Psychiatric Care		_____	_____
iii.	Swing Beds		_____	_____
iv	LTACH Beds		_____	_____

***INCLUDES** Pediatric/Orthopedic, Neonatal II and III Beds and Swing Beds.

INTENSIVE CARE, NEONATAL CARE, AND NEWBORN SERVICES

TRANSITIONAL CARE BEDS: are not to be included (Special Care, Progressive Care, Step Down Beds, Etc.) in any of the Service Unit Categories for Intensive Care Below.

Report for the Period January 1, 2010 through December 31, 2010

Service Unit	Beds in Operation at End of Reporting Period	Patients	Number of Inpatient Days
A. Intensive Care			
1. Med/Surg ICU (include mixed ICU/CCU)			
2. Pediatric ICU			
3. Cardiac Intensive Care (CCU)			
4. Burn Care			
B. Neonatal Care (exclude newborn days)			
1. Neonatal Intermediate Care (Level II)			
2. Neonatal Intensive Care (Level III)			
C. Newborn Services (include only Level I care)			
1. Bassinets in Operation			
2. Total Births			
3. Newborn Days			

CHEMICAL DEPENDENCY CARE UTILIZATION

Instructions:

- Complete this section for the utilization of **LICENSED** Chemical Dependency beds only.
- Utilization data for acute care, psychiatric care, or physical rehabilitation inpatients should not be included in this section unless beds licensed as chemical dependency were used to provide those services.

Utilization by Service

Account for the unduplicated utilization of all beds licensed for chemical dependency care, which are set up and staffed for use (beds in operation) regardless of their actual use. For example, if a patient admitted to detox was transferred to rehab and then discharged, that would count as one admission and one discharge.

Service Unit	Beds in Operation (at end of reporting period)	Number of Admissions	Number of Inpatient Days	Number of Discharges (include deaths)	Number of Discharge Days
Chemical Dependency Jan 1 - Dec 31, 2010					

Census Data:

Chemical Dependency census as of midnight, December 31, 2009 _____
 December 31, 2010 _____

Beds and Utilization by Licensure Category:

	Licensed Beds as of January 1, 2011 (per licensing And regulation)	Number of Licensed Beds January 1, 2010	Number of Licensed Beds December 31, 2010
Licensure Category Chemical Dependency		_____	_____

If number of licensed beds for Chemical Dependency changed between the first day of the reporting period and the last day of the reporting period, give date(s) of change(s): _____

Chemical Dependency Care Utilization (Cont.)

Complete all items. If there are no data for an item, please use zero.

Utilization by Specific Service

Account for the utilization of all beds used for chemical dependency care regardless of their actual licensed category. For example, if a patient is admitted to a psychiatric care bed and treated for chemical dependency, then you should complete this section.

Chemical Dependency Care Utilization						
Utilization/Service	Detoxification			Rehabilitation		
1. By Admissions	Beds in Operation	Admissions	Inpatient Days	Beds in Operation	Admissions	Inpatient Days
Alcoholism Only						
Alcoholism & Drugs						
Drugs Only						
Others (Specify)						
Total						
2. By Age Cohorts						
Children (0 - 12)						
Adolescents (13 - 17)						
Adults (18 & older)						
Total (all ages)						

Physical Rehabilitation Care Utilization

Instructions

- Complete this section only for the utilization of beds licensed for physical rehabilitation care.
- Complete all items. If there are no data for an item, please use zero.
- Utilization data for acute care, psychiatric care, or chemical dependency inpatients should not be in this section unless beds licensed as physical rehabilitation beds were used to provide those services.

Utilization by Service

Account for the unduplicated utilization of licensed physical rehabilitation beds regardless of the actual use.

Service Unit	Beds in Operation (At end of reporting period)	Number of Admissions	Number of Inpatient Days	Number of Discharges	Number of Discharge Days
Physical Rehabilitation (Jan 1 through Dec 31, 2010)					

Census Data

Physical Rehabilitation census as of midnight, December 31, 2009: _____
 December 31, 2010: _____

	Licensed Beds (per Licensing and Regulation) January 1, 2011	Number of Licensed Beds (January 1, 2010)	Number of Licensed Beds (December 31, 2010)
Licensure Category: Physical Rehabilitation		_____	_____

If number of Physical Rehabilitation Licensed Beds changed between the first and last day for the reporting, give date(s) of change(s): _____

Services / Procedures Utilization

Do not leave any items blank. If the service or procedure(s) is not provided, please use a zero.

Ambulatory Surgery Data Are To Be Reported In The Ambulatory Surgical Services Section.

Total Surgical hours are defined as the time that the operating room was in actual use. Do not include scheduled time, available time, and/or clean-up time.

Average Clean-up time between operations is to be reported in minutes.

Services/Procedures Utilization	Number Of
A. Heart Surgical Operations	
1. Adult Open-heart Operations *1,2	
2. Pediatric Open-heart Operations	
B. Inpatient Surgical Operations * (excluding heart)	
C. Operating Room	
1. Heart operating rooms (dedicated to heart)	
2. Inpatient operating rooms (exclusive inpatient use)	
3. Operating rooms (non-exclusive use **). Do not include cystoscopy rooms.	
4. Cystoscopy rooms. Do not include in (C-3) operating rooms.	
D. Service Time	
1. Inpatient Operating Rooms	
a. Total Surgical hours (Report in Whole Hours)	
b. Average Clean-up time (Report in Whole Minutes; ie. 15 min)	
E. Outpatient Utilization (Do NOT include ambulatory surgery utilization)	
1. Emergency Room visits***	
2. Other outpatient visits***	
3. Laboratory outpatient visits	

If Less Than Twelve (12) Months, Give Beginning And Ending Date Of Operation(s) in 2010: _____
(Include heart transplant operations in the total of all heart surgical operations. Angioplasty should not be counted as open-heart surgery.)

***Surgical Operations:** Defined as discrete patient encounters, whether major or minor, performed in the operating room(s). A surgical operation can involve one or more surgical procedures, but is still considered only one operation. Unless specific procedures are asked for, operations should be reported.

****Non-Exclusive:** Defined as operating rooms that are used as inpatient and outpatient use. Not exclusive to one or the other.

*****Outpatient Visit:** Defined as visits by patients who are not lodged in the hospital while receiving medical, dental, or other services. A visit consists of one or more occasions of service. (Do Not Include Labs) Example: Sue was seen for 3 tests on June 1. All 3 were in different departments. Sue had 1 actual visit.

Services/Procedures Utilization (Cont.)

Do not leave any item blank. If the service or procedure is not provided, please use a zero.

For facilities providing a lithotripsy or CT scan service, but using a mobile unit, indicate the number of mobile units with an “M” on lines F1 & G1.

Example: 1M or 2M.

Service Report for January 1 through December 31, 2010	Number Of
F. Lithotripter Procedures (ESWL)	
1. Lithotripter Units (Number of Devices)	
2. Biliary Procedures	
3. Renal Procedures	
G. Cat Scans	
1. Total CT Units (Number of Devices)	
2. Total CT Scan Procedures (Head and Body)	

If less than twelve (12) months, give beginning date of operation: _____

Names Of Mobile Unit Service(s) Used:

Lithotripter: _____

CT Scanner: _____

Services / Procedures Utilization (Cont.)

Cardiac Catheterization Procedures Section:

Hospitals are no longer required to complete the Therapeutic and Diagnostic Cardiac Catheterization Procedures portion of the Annual Hospital Utilization Survey. This change has been implemented as a result of changes in the 2010 – 2012 State Health Plan which was implemented in September 2010. The State Health Plan now specifies that cardiac catheterization utilization will be determined from administrative claims data submitted by hospitals as required by 900 KAR 7:030 – Data Reporting by Health Care Providers and be published in the Kentucky Annual Administrative Claims Data Report.

The Kentucky Annual Administrative Claims Data Report will use the administrative claims data to determine utilization. It will also use the Certificate of Need Inventory of Health Facilities and Services to determine the number of cardiac catheterization labs that have received CON approval. Please review this list on our web site at: <http://chfs.ky.gov/ohp/con/> and notify the Office of Health Policy, Certificate of Need at 502-564-9589 to resolve any discrepancies.

Services / Procedures Utilization (Cont.)

Do not leave any item blank. If a service or procedure is not provided, please use a zero.

Please indicate the number of transplant procedures by organ site and age of the recipient. The criteria for determining whether a transplant to a person 14-17 years old is to be classified as an adult or pediatric transplant rests with the hospital staff.

J. Transplant Procedures Report for the Period Jan 1 through Dec 31, 2010	ADULT		PEDIATRIC	
	14 - 17 Years	18 & Older	0 - 13 Years	14 - 17 Years
Heart				
Heart/Lung				
Lung				
Bone Marrow				
Kidney				
Liver				
Pancreas				

MRI, PET and Ambulatory Surgery

All MRI equipment should be registered with the KY MRI Registry. The Kentucky Annual Survey of Magnetic Resonance Imaging must be completed for every MRI unit in the state whether it be licensed or exempt status.

MRI is no longer part of the Hospital Utilization Services Survey, but is still required.

When you have completed the Hospital Utilization Survey the MRI Survey should also appear under the surveys to be completed. If the survey does not appear to be completed and your facility operates an MRI our office must be contacted to load the survey and register the machine. Registration of all MRI equipment within the Commonwealth of Kentucky is required.

The following information is necessary to complete the Survey and Registry:

- 1. County of service, administrators contact information and respondents contact information.**
- 2. Make, Model and serial number for each MRI machine.**
- 3. Number of procedures and patients served.**
- 4. Number of devices stationed on site.**
- 5. Number of hours per week machine is operational.**

The Positron Emission Tomography (PET) data is no longer part of the Hospital Utilization Survey. All PET data is to be reported on the PET survey.

Ambulatory Surgical Services data is no longer part of the Hospital Utilization Survey. All Ambulatory Surgical Data should be reported on to the Ambulatory Surgical Services Survey.

Certification and Verification Section

On behalf of the administration the information contained in this report is complete and accurate. After reviewing the information contained in this report, I hereby submit it as an official record of the hospital's activity in compliance with 902 KAR 20:008 (rev 10-15-03) and 900 KAR 6:125.

Policies regarding data submission and changes to data can be reviewed on the OHP web site: <http://chfs.ky.gov/ohp/>. By signing you are certifying this data is correct.

Signed_____

Date_____

Special Note: It will not be necessary for you to return this form online data submission is required.

NOTICE: Please review the data entered on this survey. Check that all questions have been answered accurately and in full. Refer to the instructions for each section if you have any questions. If any part of the survey is not clear to you, please call Beth Morris in the Office of Health Policy at (502) 564-9592 or email betha.morris@ky.gov before submitting the survey. It is important to complete this survey accurately by the deadline in order to be in compliance with licensing and certificate of need requirements. Please complete and submit the Hospital Utilization Survey on the following Internet Web Site: <https://apps.chfs.ky.gov/OHPSurvey/Default.aspx>. Once the data has been received, edited, and published by this office, no changes will be made.